

Tobacco Taxes

and their impact on populations
of low socioeconomic status



Contributors

Break Free Alliance Coordinating Council

Bruce W. Adkins, P.A., MS
Director, Division of Tobacco Prevention
West Virginia Bureau for Public Health

Robert H. Anderson, MA, CHES
Prevention Research Center, West Virginia University

Marva Brooks
Health Disparities Coordinator
Wisconsin Department of Health & Family Services
Tobacco Prevention and Control Section

Tamatha Thomas-Haase, MPA
Manager, Training and Program Services
North American Quitline Consortium

Debra G. Morris, MPH, CHES
Director of Technical Assistance
Tobacco Technical Assistance Consortium

Health Education Council Staff

Debra S. Oto-Kent, MPH
Executive Director
Health Education Council

Janet Porter, MPH, CHES
Program Director, Break Free Alliance
Health Education Council

Lisa Houston, MPH
Program Administrator, Break Free Alliance
Health Education Council

Kristi Maryman, BS
Program Coordinator, Break Free Alliance
Health Education Council

INTRODUCTION AND BACKGROUND

Break Free Alliance first addressed the issue of tobacco taxes and their impact on low SES communities in 2002 as the National Tobacco Prevention Network. In an article titled, *Tobacco Taxes and Their Impact on Low SES Populations*, the Network took the position that the impact of increased tobacco taxes on low-income communities can be further offset when additional tax revenues are used to finance prevention and cessation programs that target the poor. In light of the increase in the federal tobacco excise tax which took effect April 1, 2009, increasing the tax on cigarettes from 39 cents to \$1.01 per pack, this Break Free Alliance brief revisits the issue, summarizes recent studies, and provides recommendations for advocates for directing funding back into tobacco prevention and cessation programs that serve low SES individuals.

For the purposes of this document, Break Free Alliance broadly defines individuals of low SES as those with 12 years of education or less, and those with low incomes (either at or below the Federal poverty level). Characteristics that may also describe low SES populations include the medically underserved, the unemployed, and the working poor.

PREVALENCE

During the past 40 years, smoking prevalence has declined overall and among each sociodemographic subpopulation. However, large disparities in smoking prevalence continue to exist by race/ethnicity and education level. The continuing higher prevalence among several populations, such as persons with GED diplomas (41.3%), and persons reporting family incomes below the federal poverty level (31.5%), emphasizes the need for more effective policy and environmental and individual-level interventions to reach and assist these subpopulations. Data for 2008 also indicates that those with 9–11 years of education had a 35.7% smoking rate, while adults with an undergraduate or graduate degree had respective rates of 10.6% and 5.7%. Among the general population, approximately 20.6% (46 million) of adults were current smokers in 2008 [1].

Americans living in poverty suffer disproportionately from tobacco-related morbidity and mortality. This may be due to the fact that people living in poor communities are less likely to have access to cessation programs or receive cessation advice. In addition, individuals living in poor neighborhoods are more likely to be influenced by tobacco industry marketing and more likely to purchase tobacco products.

Clearly, smoking cessation has immediate and long term benefits for men and women of all income and education levels. The risk of lung and other cancers, cardiovascular diseases, chronic lung diseases, and acute heart attack all significantly decrease when individuals quit smoking [2]. In order to reduce tobacco use prevalence among individuals of low income and low educational attainment, funding must be directed to programs to prevent youth initiation and increase cessation rates for current users.

THE ISSUE OF REGRESSIVITY

Traditionally, taxes on tobacco have been viewed as regressive. A regressive tax is one for which the poor pay a higher percentage of their income in taxes than do the rich [3], as is the case for tobacco products in that they are most often consumed at a greater proportion by the low SES population [4]. Public health advocates have generally supported taxes on tobacco products because of the harm that smoking does to both smokers' health and that of others. The Centers for Disease Control and Prevention, Office on Smoking and Health, considers tobacco tax increases an important policy tool that can reduce smoking rates and fund state anti-tobacco programs [5].

Economic analysis does show that cigarette taxes heavily burden poor smokers who do not quit [6]. However, there is no doubt that increasing the price of tobacco products through increases in excise taxes is an effective policy intervention to reduce initiation by youth and young adults, reduce tobacco product consumption, and increase cessation attempts by those wanting to quit. The argument that the regressivity of tobacco taxes can be offset with targeted prevention/cessation programming for low SES populations has merit. The problem is that few states have dedicated a portion of new tax revenues to support health programs.

A REVIEW OF THE LITERATURE

There is clear evidence that one of the most effective tools to reduce smoking in the general population has been tobacco taxes. The evidence is less clear as to whether tobacco taxes result in significant reductions in smoking among low SES populations.

Numerous economic studies and peer-reviewed journals have documented that cigarette price increases can lead to significant reductions in smoking among current smokers and in the number of people who start smoking [7]. In addition, young people, pregnant women, and other price sensitive groups, are considered especially sensitive to tobacco price increases [8]. Increasing the price of tobacco products results in more cessation attempts and reduces the level of initiation of tobacco use [9]. Further, youth are more impacted by price increases because they have less expendable income [10]. A 10% increase in the real price of cigarettes is estimated to reduce consumption by nearly 4% in the general population [11]. The Task Force on Community Preventive Services recommends price increases through excise taxes as an effective policy intervention to prevent smoking initiation by adolescents and young adults, reduce cigarette consumption, and increase the number of smokers who quit [12].

In the wake of significant budget shortfalls, many states have increased cigarette and other tobacco product excise taxes to boost revenues. These increases in price have been studied to examine whether or not increasing the price of tobacco products has an impact on smoking cessation decisions of young adults, thereby influencing public health. The estimates clearly indicate that increasing the price of cigarettes increases the number of young adults who quit smoking. Given the well-documented benefits of smoking cessation, a significant increase in cigarette excise taxes may be one of the most effective means to reduce premature death and disease in the United States [13].

Smokers living in U.S. households at lower than the median income level were about 4 times more responsive to cigarette prices than smokers in households at higher than

the median income level [14]. Higher tobacco taxes can lead to the young and the poor to quit smoking or not start in the first place. Some studies report that youth and low income people are much more sensitive to the price of goods. Furthermore, such a price increase, where it leads toward the poor to cease using tobacco, could lead to reallocating their limited funds to food, housing, education and health care [15].

BREAK FREE ALLIANCE DATA

In 2002, Break Free Alliance conducted focus groups in four different health centers in the United States and observed that smoking behavior does not significantly change in response to price increases. Focus group sites were chosen based on states with the highest tobacco use rates, including Arkansas, Nevada, New Mexico, and West Virginia. All were members of the National Association of Community Health Centers. Two focus groups were convened at each site, with 6-10 participants in each group. All participants in the focus group were between the ages of 25 to 34 years of age, of low socioeconomic status, and current smokers.

Four main topics were explored during the focus groups: 1) current smoking behavior and attitudes; 2) brands and cost; 3) smoking and health; and 4) smoking cessation. Results indicated that price increases do not lead to cessation. Most participants reported that when the price of tobacco increases, they simply switch to less expensive brands, purchase from non-traditional suppliers, or roll their own cigarettes. Although many want to quit and attempt cessation, the majority simply “switch down” to a less expensive brand [16].

The Break Free Alliance focus group findings are consistent with studies that have looked at the impact of higher taxes on low income households and found that smoking behavior changes less in response to higher cigarette prices. Spending on cigarettes in these households can rise, further crowding out spending on other goods and services [17].

THE OPPORTUNITY FOR STATES

For the low income populations we serve, this creates a dilemma: Does the benefit to those that respond to price increases outweigh the cost to those that continue to smoke? Increases in state and federal cigarette excise taxes per pack since 1995 have provided an important contribution to preventing tobacco use and promoting cessation. The Institute of Medicine (IOM) concluded that because excise taxes place a disproportionate burden on lower-income smokers, revenue from excise tax increases should be coupled with existing governmental financing to support cessation programs and services, especially for lower-income smokers. Telephone-based tobacco-use quitlines are an example of existing cessation services that might be expanded using excise tax revenue [18].

State cigarette excise tax increases across the U.S. have increased revenue and decreased cigarette consumption, often resulting in declines in prevalence [19]. Overall, higher prices potentially reduce cigarette consumption through three channels: by

decreasing initiation, by increasing cessation, and by decreasing daily consumption of current smokers [20].

Smoking-related death and disease carry a high cost, not only emotionally for the families coping with such tragedy, but also for the health system and economy at large. Cigarette smoking and exposure to secondhand smoke result in approximately 443,000 premature deaths, 5.1 million years of potential life lost, and \$97 billion in productivity losses in the United States each year [21]. Comprehensive tobacco control program and policy recommendations have been provided to the public health community with the goal of reducing tobacco use and secondhand smoke exposure so that they are no longer a significant public health problem in the United States [5, 22].

Indeed, tobacco tax increases are an important policy tool that can reduce smoking rates and fund state anti-tobacco programs [18], however, few states are investing tax revenues in programs to combat tobacco use specifically among low SES populations, while some are making dramatic cuts in spending on existing tobacco programs. The current trend could impact low SES populations and their ability to obtain the resources they need to quit along with messages to prevent further initiation. Based on documented high prevalence rates of low SES smokers, states should make the greatest possible efforts to motivate and assist smokers to quit. The decision to divert tobacco tax revenues into non-tobacco related programs may eventually yield higher smoking rates, or at the very least the leveling off of the downward trend the U.S. has enjoyed, and to future increases in related health care costs. Clearly, there is a rational case for dedicating a share of the tax revenue to funding campaigns and support for smokers, with particular emphasis on low SES smokers.

CONCLUSIONS AND RECOMMENDATIONS:

- Advocates Should Support Tobacco Tax Increases: Break Free Alliance supports tobacco tax increases. Tax increases deter youth from starting and encourages some adults to quit. However, because an increase in the tobacco tax falls disproportionately on low income individuals, we believe any tax revenues should be used primarily to benefit them. Any tobacco tax increase should have a portion of the increased revenues allocated to tobacco and other chronic disease programs targeted to the low SES population. Examples of specific interventions include but are not limited to:
 1. Collaborating with social service organizations who serve the poor to assist with outreach and promotion of state quitline services.
 2. Partnering with not-for-profit organizations, such as faith-based agencies, homeless service providers and substance abuse treatment facilities to integrate brief cessation counseling and client support.
 3. Collaborate with correctional institutions to assist them with adopting policies prohibiting tobacco use and integrating cessation support for inmates and staff and as a component of discharge planning.
- Remember that Affordability and Addiction are Two Different Things: Tax increases alone should not be viewed as an effective cessation method for the

poor. This makes the assumption that the issue is one of affordability, when it is actually one of addiction. Tax increases should be coupled with appropriate cessation resources tailored to low SES subgroups.

- Advocates Should Continue to Work on Strategies that Change the Social Norm: Smoking is still normative behavior in poor communities. Therefore, even though tobacco may become more expensive to purchase, the social norm in poor communities keeps tobacco products “affordable”. Individuals will continue to borrow from other users, buy single cigarettes, and support each other in their addiction. Some promising practices to address social norm change include:
 1. Assisting agencies who provide services in low SES communities to adopt strong policies prohibiting tobacco use among clients/consumers on the grounds of the facility and to integrate cessation programming into their continuum of care.
 2. Continue to work on the passage of local ordinances prohibiting tobacco use in worksites, bars, parks, day care centers, public housing, personal automobiles, etc.
 3. Make sure social service providers are in compliance with state indoor air laws. Many shelters, bars (especially in rural areas), and social service providers may ignore laws and continue to allow smoking to appease their clientele and employees.
- Monitoring of Tobacco Advertising in Low SES Communities Must Continue: The tobacco industry continues to target the poor with advertising and employ tactics that offset tax increases in poor neighborhoods. By monitoring this in your state, you can continue to educate community leaders and policy makers to address the issue.
- States Should Take Advantage of Medicaid Match: Because of the State’s high federal match for Medicaid, the impact of the tobacco tax could be tripled by investing some of these revenues in Medicaid tobacco prevention efforts, such as funding tobacco quitlines or providing nicotine replacement therapy (NRT) specifically for this population. States could elect to use a portion of tax revenues to fund programs such as state earned income tax credit or child care assistance to help low SES residents. The declining nature of the tobacco tax to fund government services will present challenges in future years. However, the health benefits of a cigarette tax and the opportunity to help thousands of the low income population with improved health care clearly outweigh the shortcomings of the tax.
- Population-Based Strategies Must Be Linked with Tailored, Effective Programming: There must be a continual push for more funds from the Master Settlement Agreement (MSA) and/or dedicated funds from tobacco tax increases for provision of proven tobacco control programming efforts, and for culturally and linguistically appropriate programs to support cessation and quitlines. While best practices have been shown to make an impact in the general population, they are not always transferable to low SES communities. Tailored, community-based interventions remain the best approach for reducing tobacco prevalence among populations of low SES.

- State Quitline Services Must Be Promoted to Low SES Populations: Work with your state quitline service provider to develop tailored outreach campaigns to low SES populations. Social service providers, community clinics and others can promote the quitline to their consumers.
- Provide Grassroots Organizations with Support to Mobilize Local Advocates: Encourage community mobilization efforts to send a message to policy and decision makers that their constituents support funding for tobacco prevention and cessation programs, especially those that target low SES consumers. Let policy makers know that by providing programs for low SES communities, their state will see their health care costs gradually decline as prevention and cessation programs reduce tobacco use.

The Break Free Alliance should be considered as a foremost resource for those seeking information or in need of consultation on tobacco use and low SES populations. The goal of the Alliance is to engage key organizations serving low SES populations in tobacco control efforts and to assist them with resource development and assessments, technical assistance, capacity building, and evaluation to prevent and reduce tobacco use among their constituents. Additional information and specific contact information can be found at: <http://healthedcouncil.org/breakfreealliance/index.html>

References

1. Centers for Disease Control and Prevention, *Cigarette smoking among adults---United States, 2008*. MMWR, 2009. **58**(44): p. 1227-1232.
2. U.S. Department of Health and Human Services, *The Health Consequences of Smoking: A Report of the Surgeon General*. 2004, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
3. Stiglitz, J., *Economics of the Public Sector, 3rd edition*. 2000, New York, NY: WW Norton & Company.
4. Lyon, A. and R. Schwab, *Consumption taxes in a life-cycle framework: are sin taxes regressive?* Rev Economics Stat, 1995. **77**: p. 389-406.
5. Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs—2007*. 2007, US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health: Atlanta, GA.
6. Remler, D.K., *Poor smokers, poor quitters, and cigarette tax regressivity*. Am J Public Health, 2004. **94**(2): p. 225-9.
7. U.S. Department of Health and Human Services, *The Health Benefits of Smoking Cessation: A Report of the Surgeon General*. DHHS Publication No. (CDC) 90-8416 ed. 1990, Rockville, MD: Public Health Service, Centers for Disease Control, Office on Smoking and Health
8. US Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*. 2000, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Helath Promotion, Office on Smoking and Health: Atlanta, GA.
9. National Cancer Policy Board, *Taking action to reduce tobacco use*. 1998, Washington, DC: National Academies Press.
10. Grossman, M. and F.J. Chaloupka, *Cigarette taxes. The straw to break the camel's back*. Public Health Rep, 1997. **112**(4): p. 290-7.
11. Jha, P. and F. Chaloupka, *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. 1999, Washington, DC: The World Bank.
12. Task Force on Community Preventive Services, *Guide to community preventive services: tobacco use prevention and control*. American Journal of Preventive Medicine, 2001. **20**(2 Suppl 1): p. 1-87.
13. Tauras, J.A., P.M. O'Malley, and L.D. Johnston. *Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis*, 2001; NBER Working Paper No. W8331. Available from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=273699. Accessed January 11, 2010.
14. Farrelly, M.C., et al., *Response by Adults to Increases in Cigarette Prices by Sociodemographic Characteristics*. Southern Economic Journal, 2001. **68**(1).
15. World Health Organization. *WHO Report on the Global Tobacco Epidemic, 2008*. Available from: <http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=6&codcol=93&codcch=220>. Accessed January 11, 2010.
16. Anderson, R.H., et al., *Smoking Habits and Prevention Strategies in Low Socio-economic Status Populations*. 2004, Health Education Council: Sacramento, CA.
17. Chaloupka, F.J., *Smoking, food insecurity, and tobacco control*. Arch Pediatr Adolesc Med, 2008. **162**(11): p. 1096-8.
18. Centers for Disease Control and Prevention, *Federal and State Cigarette Excise Taxes --- United States, 1995—2009*. MMWR, 2009. **58**(19): p. 524-527.
19. Campaign for Tobacco-Free Kids. *Raising state cigarette taxes always increases state revenues (and always reduces smoking)*, 2009. Available from: <http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=18>. Accessed Jan 11, 2010.
20. Decicca, P., et al., *Youth smoking, cigarette prices, and anti-smoking sentiment*. Health Econ, 2008. **17**(6): p. 733-49.
21. Centers for Disease Control and Prevention, *Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses --- United States, 2000--2004*. MMWR, 2008. **57**(45): p. 1226-1228.
22. Bonnie, R., K. Stratton, and R. Wallace. *Ending the Tobacco Problem: A Blueprint for the Nation*, 2007. Available from: http://books.nap.edu/openbook.php?record_id=11795. Accessed Jan 11, 2010.



SUMMARY SHEET

Tobacco Taxes and Their Impact on Populations of Low Socioeconomic Status

RECOMMENDATIONS:

- **Tobacco tax increases should be supported, as these tax increases deter youth from starting and encourage some adults to quit.** However, because an increase in the tobacco tax falls disproportionately on low-income individuals, some tax revenues should be used primarily to benefit them. Any tobacco tax should have a portion of the new revenues generated be applied to tobacco and other chronic disease programs targeted to the low SES population.
- **Tax increases should be coupled with appropriate cessation resources tailored to low SES subgroups:** Tax increases alone should not be viewed as an effective cessation method for the poor. This makes the assumption that the issue is one of affordability, when it is actually one of addiction. Studies indicate that when the cost of cigarettes increase, poor smokers will divert money spent on food to spending on cigarettes.
- **Advocates Should Continue to Work on Strategies that Change the Social Norm and Acceptance of Tobacco Use.**
- **Monitoring of Tobacco Advertising in Low SES Communities Must Continue.** The tobacco industry continues to target the poor with advertising and employ tactics that offset tax increases in poor neighborhoods. By monitoring this in your state and local communities, you can continue to educate community leaders and policy makers to address the issue.
- **States Should Take Advantage of Medicaid Match:** Because of a State's high federal match for Medicaid, the impact of the tobacco tax could be tripled by investing it in Medicaid tobacco cessation and prevention efforts, such as funding tobacco quitlines or providing nicotine replacement therapy (NRT) specifically for this population.
- **Population-Based Strategies Must Be Linked with Tailored, Effective Programming:** Quitline cessation services alone will not significantly reduce smoking prevalence in low SES populations. Quitline services must be coupled with community-based cessation interventions. Advocacy efforts must be continued for more funds from the Master Settlement Agreement (MSA) and/or dedicated funds from tax increases for provision of proven prevention efforts, and for culturally and linguistically appropriate programs to support cessation at the community level.
- **State Quitline Services Must Be Promoted to Low SES Populations:** State quitline services need be tailored with outreach campaigns to low SES populations.
- **Provide Grassroots Organizations with Support to Mobilize Local Advocates:** Let policy makers know that by providing cessation programming for low SES communities, their state will see health care costs gradually decline as prevention and cessation programs reduce tobacco use.

The Break Free Alliance should be considered as a foremost resource for those seeking information or in need of consultation on tobacco use and low SES populations. The goal of the Alliance is to engage key organizations serving low SES populations in tobacco control efforts and to assist them with resource development and assessments, technical assistance, capacity building, and evaluation to prevent and reduce tobacco use among their constituents. Additional information and specific contact information can be found at: <http://healthedcouncil.org/breakfreealliance/index.html>



Health Education Council
3950 Industrial Boulevard, Suite 600
West Sacramento, California 95691
Phone (916) 556-3344
Fax (916) 446-0427

healthedcouncil.org



HEALTH
EDUCATION
COUNCIL